Group Medical Insurance Policy – India

Key definitions & related documents

Key definitions

Policy Period: Duration of one year starting from **November 01, 2024 - October 31, 2025.**

Enrollment window: Associates who wish to modify/add dependents may do so during the enrollment window once in a year at the time of renewal or at the time of joining.

Midterm: In the middle of the policy period.

Coverage: The extent of the sum insured provided under this policy.

Base policy (GMC): Base Policy provides hospitalization benefits for the associate and three dependents enrolled by the associate.

Parents: Biological Parents, excludes stepparents and in-laws.

Children: Coverage limited to three biological children, excludes stepchildren.

Spouse: Legally married and not under the purview of child marriage guidelines.

AMC (Additional Member Cover) **policy:** Associate can add two (2) additional dependents limited to two (2) biological children, parents, parents in law, siblings (special child or unmarried sister) by paying additional premium.

Top-up policy: Associate can enhance coverage for Base cover or Base and AMC cover by paying additional premium.

Day Care Treatment: A patient who is admitted in a registered hospital or nursing home or clinic for treatment that does not require an overnight admission or 24 hours hospitalization.

Outpatient Department (OPD): Treatments that don't require a patient to get admitted in the hospital or nursing home or clinic.

Inpatient: Treatments that requires a patient to get admitted in the hospital for more than 24 hours with an active line of treatment.

Pre-Existing Disease: Any existing ailment/ disease/ injury that the person has, prior to the commencement of the policy.

Primary Insurer: The insurance provider for this policy.

Third Party Administrator (TPA): A registered body engaged by the insurer for processing claims.

Network Hospitals: List of hospitals empaneled by TPA / Insurer.

Non-Network Hospitals: Hospitals that don't fall under the empaneled list of TPA / Insurer.

Registered Hospital / Nursing home / Clinic: Hospital/Nursing home/clinic registered under any local government authority or has at least 15 beds, with qualified nurses round the clock, qualified duty doctors along with a fully equipped operation theatre.

Congenital Anomaly: Presence of an ailment since birth and that is abnormal with reference to form, structure, or position.

Co-pay: Refers to the portion of claim that must be borne by the Associate.

Room Rent: Rent and boarding expenses as provided by the hospital including nursing charges.

Proportionate Deduction: Ratio by which room rent and boarding charges exceed the room rent limit. The claim admissible amount excluding the pharmacy is reduced by the same proportion.

Loss of pay (LOP): Payment made by insurer in lieu of loss of salary with respect to any critical illness as defined in the policy.

Maternity Expenses: Expenses that are traceable to childbirth or lawful termination of pregnancy.

Related policies & processes

FAQ

Scope

The policy applies to all employees, on the payrolls of Cognizant Technology Solutions India Private Limited ("Cognizant") and its affiliates and subsidiaries over which Cognizant India has operational control, in the course of employment (collectively "Associates"). The policy covers treatments undertaken only in India.

Guiding principles

This policy provides hospitalization benefits for Associates and their enrolled dependents. The policy is administered through:

- **Primary Insurer**: The New India Assurance Company Limited, herein referred to as NIA.
- **Third Party Administrator (TPA):** Medi Assist Insurance TPA Private Limited, herein referred to as Medi Assist.

Associate must declare or nominate their dependents every year during open enrollment/Enrollment window. There is no option of auto carry forward.

Coverage

The policy provides coverage for hospitalization expenses, with an active line of treatment which fulfills a minimum requirement of 24 hours of hospitalization, with time limit waiver for certain ailments (Day Care Treatments). Associates and their dependents are covered through a floater coverage in the Base policy. Coverage is provided for newborn from the date of birth. Pre-Existing conditions are covered under the policy from day one of joining Cognizant. Associates can also avail Additional Member Cover (AMC) and/or Top-up cover based on their needs by paying premium.

All eligible Associates covered under the Base Policy, AMC, and Top up would include:

- Associates hired in India and are currently in India.
    - Associates can also opt for an Additional Member Cover (AMC) and Top-up cover, under the India Medical Insurance policy, at the time of joining Cognizant or during the policy renewal period/Enrollment window.
    - Associates cannot make changes to their dependent details anytime during the Policy Period or post their travel back to India from onsite. Changes to the dependent details can be made only at the time of renewal.
- Associates who are hired at an onsite geography, upon travelling to India, on India employment as specified in the assignment letter or associated benefits statement.
    - Associates will be provided with an option of adding/updating their dependent details on the Base policy upon travelling to India within 14 days of their payroll transfer to India only once during Policy Period.
    - Coverage for self and enrolled dependents under Base Policy, will be valid till the end of the Policy Period or until their stay in India, whichever is earlier.
    - AMC and Top-up cover, if purchased, will be valid for dependents based out of India till the end of the Policy Period, even if they travel back to their home country within the same Policy Period.
    - AMC and Top-up covers will be valid till the end of the Policy Period or until their stay in India, whichever is earlier.
    - If there is an active registration of claim during enrollment / renewal window, the Associate will not be able to modify the Top-up benefit.
    - If there is an active registration of claim during enrollment process for new joiners, Associate will not be able to modify the Top-up benefit.

Eligible Dependents under Base policy

Associates can enroll a maximum of three dependents, that include:

- Spouse (minimum age limit of 21 years)
- Parents (as per regulatory guidelines)
- Children (up to the age of 25 years)

Note:

- Foster parents are not eligible for coverage.
- Adopted children can be enrolled into the policy within 45 days, once the legal adoption certificate is received.

Eligible Dependents Under AMC policy

Associates can enroll a maximum of two (2) dependents, that include:

- Parents (as per regulatory guidelines)
- Parents-in-law (as per regulatory guidelines)
- Children (up to the age of 25 years)
- Disabled dependent sibling.
- Unmarried sister

Note:

- Foster parents are not eligible for coverage
- Maximum of three (3) children can be added in the Base policy and AMC policy.
- Adopted children can be enrolled into the policy within 45 days once the legal adoption certificate is received.
- Associate cannot enroll same member in both Base and AMC policy

Base policy Coverage limits

The following table describes the coverage limits under the Base Policy based on the level of an Associate:

Levels	Coverage (Floater Sum Assured)
Levels up to Associate	INR 250,000
Senior Associate and Managers	INR 300,000
Senior Managers & above	INR 500,000

Room rent cap (including boarding and nursing expenses) as per levels for Base Policy is as follows:

Room rent cap for Base policy			
Level	**Sum Insured**	**Eligible room rent (per day inclusive of nursing charges)**	**Eligible ICU room rent (per day)**
Up to Associate	INR 250,000	INR 4,000	On Actuals
Sr Associate & Managers	INR 300,000	INR 4,000	On Actuals
Sr Managers & above	INR 500,000	INR 6,000	On Actuals

Expenses covered

Expenses covered under hospitalization include:

- Surgeon, Anesthetist, Medical Practitioner Consultants, Specialists Fees.
- Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs & Cost of Organs, and similar expenses.
- Ambulance services per hospitalization is 1 % of sum insured or INR 2000, whichever is lesser.
- Refer Annexure I for non-medical expenses excluded from coverage.

Additional Member Cover (AMC) policy
Associates can at the time of joining Cognizant or during renewal of the policy/Enrollment window, opt for an Additional Member Cover.

- The premium for AMC must be paid by the Associate.
- Upon opting for AMC, the Associate may choose to include a maximum of two (2) additional dependents into the policy.
- Associate may add a newborn baby within 45 days from the date of birth, subject to availability of vacant slots. No other changes can be done to the AMC enrollment Midterm.
- Any claim pertaining to the new member prior to enrolment /endorsement / premium payment will not be admissible.

The premium details for AMC are as mentioned below:

AMC Sum Insured (INR)	AMC policy premium– Age band (in years) and premium per member (in INR) W.E.F. November 01, 2024							
	0-35	36-45	46-55	56-65	66-70	71-75	76-80	Above 80
100,000	4,557	5,221	7,887	16,543	18,541	21,209	22,539	24,802
200,000	7,133	7,941	11,987	27,366	30,605	34,649	37,081	40,802
300,000	9,181	10,031	15,982	34,685	38,932	44,880	47,431	52,188

- The premium towards AMC as mentioned in the above table is inclusive of GST. However, this is subject to change from time to time based on changes in GST rates.
- The additional members opted under AMC policy would have the applicable room rent / ICU limit (including boarding and nursing expenses) as mentioned below:

AMC Sum Insured (INR)	Eligible room rent per day inclusive of nursing charges	Eligible ICU room rent per day
100,000	INR 2,500	On Actuals
200,000	INR 2,500	On Actuals
300,000	INR 3,000	On Actuals

Top-up policy
The Top-up policy allows the Associate to increase the sum insured under the Base policy as well as AMC policy. Associates can opt for Top-up at the time of joining Cognizant or during renewal of the policy/Enrollment window.

- Top-up for AMC policy will be applicable only when the sum insured opted under AMC is INR 300,000. Associates who have availed AMC with a sum insured of INR 100,000 or 200,000 are not eligible to top-up the AMC policy.
- The premium for Top-up policy must be paid by the Associate.
- Once an Associate opts in for Top-up policy and opts out in the subsequent year, the Associate will not be permitted to top-up at later years.
- Room rent is capped as per the policy (Base or AMC) of the member. Associates opting for a higher category of room will have to bear the room rent difference as well as the proportionate expenses. This will apply to both cashless and reimbursement claims. Maximum deduction under proportionate charges is limited to 20% of claim admissible amount for all claims under Base, AMC and Top-up policies.
- No changes can be done to the Top-up policy during the Midterm including increasing / decreasing the Top-up sum insured.
- There are twelve coverage options to choose from and the premium rates below are effective **November 01, 2024.**

Top-up policy premium

Top-up Sum Insured (INR)	Premium (INR)	
	Applicable to Base policy only	Applicable to Base + AMC Policy
100,000	5,533	7,744
200,000	6,916	9,681
300,000	9,681	12,449
400,000	11,917	15,045
500,000	18,356	22,847
600,000	23,953	28,745
700,000	28,745	32,336
800,000	32,851	36,954
900,000	39,594	44,543
1,000,000	43,997	49,493
1,500,000	75,015	84,385
2,000,000	100,022	112,513

The premium towards Top-up policy mentioned in the above table is inclusive of GST. However, this is subject to change from time to time based on changes in GST rates.

The Additional Member Cover (AMC) and Top-up cover opted (if any), for the Policy Period will get expired at the end of the Policy Period. Hence, Associates are required to revisit the Medi Assist app, during the renewal enrolment period and opt for AMC and Top-up benefit to increase their insurance cover.

Validity of AMC & Top-up covers

Category	AMC validity period	Top-up validity period
Associates hired in India and currently in India	**Active on India Payroll:** Valid till the end of the Policy Period. **Separation**: Valid till the Last Working Day (LWD). **Travel on global assignment:** Till the end of the Policy Period.	**Active on India Payroll:** Valid till the end of the Policy Period. **Separation:** Valid till the LWD. **Travel on global assignment:** Till the end of the Policy Period.
Onsite hires on assignment in India at the time of renewal or during the Policy Period	**Active on India Payroll:** Valid till the end of the Policy Period. **Separation:** Valid till the LWD. **Travel back to parent or other countries:** Till the end of the Policy Period.	**Active on India Payroll:** Valid till the end of the Policy Period. **Separation:** Valid till the LWD. **Travel back to parent or other countries:** Till their stay in India Payroll.

Proportionate Deductions
If the insured is admitted in a higher room rent category, the Associate shall bear the room rent difference as well as the proportionate expenses on all other charges. This shall apply to both cashless and reimbursement claims.

- Proportionate deductions are applied on charges towards the surgeon, assistant surgeon, operation theater, anesthetist investigations and any other charges that may vary as per room category.
- Maximum deduction under proportionate charges is limited to 20% of claim admissible amount for all claims under Base, AMC and Top-up policies.
- Weighted average method will be used for determining proportionate deductions regarding room rent.

Co-pay

- A Co-pay of 10% shall be applicable on the admissible claim amount for the hospitalization (including Pre and Post Hospitalization) of the Associate, spouse and children
- A Co-pay of 15% shall be applicable on the admissible claim amount for the hospitalization (including Pre and Post Hospitalization) of the Associates' dependent parents, parents-in-law and siblings
- No Co-pay for hospitalization resulting in death of the Associate.
- No Co-pay for hospitalization due to critical illness for Associate only.

Claimant	Applicable Co-pay	Illustrative claim amount	Co-pay calculation	Co-pay
Associate	10% of the admissible claim amount	INR 90,000	INR (10% x (90,000))	INR 9,000
Parents	15% of the admissible claim amount	INR 90,000	INR (15% x (90,000))	INR 13,500

Pre & Post Hospitalization Expenses
These are medical expenses that are incidental to the hospitalization. Prehospitalization expenses refer to the expenses that are incurred for a period of 30 days before the date of hospitalization and post hospitalization expenses refer to the expenses incurred for a period of 60 days from the date of discharge.

- For example, while expenses incurred on a routine (medical) scan are not covered under the policy, expenses incurred on such scans leading to the diagnosis of an included ailment and to subsequent hospitalization for its treatment, will be covered.
- While routine consultation fee paid to the medical practitioner is not covered under the policy, should such consultation result in the diagnosis of an included ailment and to subsequent hospitalization for its treatment, the expenses incurred will be covered.
- In simple terms, any medical expenses incurred 30 days before the hospitalization which is related to the ailment diagnosed will be covered under pre-hospitalization. Similarly, after discharge any medical expenses incurred for 60 days will be covered as post hospitalization expenses.

Specific coverages

Maternity Benefits
The annual maternity cap (sub limit to the floater coverage) will be INR 50,000 for normal delivery and INR 75,000 for C-Section and is limited to the first two living children. This cap is inclusive of both pre & post hospitalization expenses. Those insured persons who are already having two or more living children will not be eligible for this benefit.

- No cap for abdominal operation for extra uterine pregnancy (Ectopic / Tubular pregnancy). Associate shall provide all necessary documentation that include ultra-sonographic report and a medical certificate from a gynecologist that it is life threatening.

- If both the Associate and the Associates' Spouse are on the rolls of Cognizant India, both can avail the maternity benefit subject to proper bills that are reasonable and customary.
- Expenses incurred in connection with voluntary medical termination of pregnancy during the first 12 weeks from the date of conception are not covered.
- Expenses relating to the baby at the time of delivery (normal baby care) will be covered within the maternity cap.
- Pre-natal and post-natal expenses are not covered unless admitted in the hospital and treatment is taken there. Hospitalization related to maternity during the gestation period will be processed within the maternity cap limit only.

Infertility
Treatment of infertility will be covered, subject to maximum of INR 40,000, for self or spouse, only if there are no living children. Cost needs to be incurred at a hospital; however, the 24-hour hospitalization clause does not apply. Once utilized, there will be no payment in subsequent years for self and spouse.

Hysterectomy
Treatment of hysterectomy will be covered, subject to a maximum of INR 75,000 per claim.

Total Knee Replacement
Treatment of total knee replacement will be covered, subject to a maximum of INR 200,000 per knee and INR 300,000 for bilateral replacement (two knees) in a single admission. This cap limit is inclusive of both pre & post hospitalization expenses.

Cataract
Cataract surgery is capped at INR 35,000 per eye.

Covid
Covid coverage is limited to inpatient, hospitalization for a minimum 24 hours.

Ayush
Expenses incurred for Ayurvedic / Homeopathic / Unani treatment are admissible provided the treatment for Illness and accidental injuries, is taken in AYUSH Hospital (Government Hospital or in any institute recognized by Government and /or accredited by Quality Council of India / National Accreditation Board on Health, excluding centers for spas, massage and health rejuvenation procedures)

External Congenital Illness (covered only under GMC policy)
External congenital illness (a condition existing at birth and often develops during the first month of life) is covered. The list of congenital external disorders that are covered under the policy is as below:

Face, Neck & Head
- Cleft Lip
- Cleft Palate
- Congenital Thyroid Cyst
- Obstructive Hydrocephalus

ENT
- Microtia/Anotia
- Cup & Bat Ears

Eye
- Congenital Cataract
- Ptosis
- Entropion
- Strabismus diagnosed within 3-6 months of birth

Genitourinary System
- Testicular Torsion
- Varicocele
- Orchidopexy
- Undescended Testis
- Hypospadias (Coverage is limited to INR 50,000)

Orthopedics
- Crowe Grade III & IV of Congenital Hip Dysplasia
- Congenital Kyphosis
- Knee Dislocation
- Congenital Talipes Equinovarus (Club Foot)
- Congenital muscular torticollis
- Pes Cavus
- Syndactyly
- Pectus excavatum

Neurological
- Spina Bifida
- Meningocele
- Craniosynostosis

Dermatological
- Hamartoma Excision
- Hemangioma Excision
- Congenital Dermal Sinus

Critical Illness

Critical Illness is defined (as per IRDA Guideline) as first-time occurrence of the following:
- Cancer of specified severity
- First heart attack of specified severity
- Open Chest - CABG
- Open heart replacement or repair of heart valves
- Coma of specified severity
- Kidney failure requiring regular dialysis
- Stroke resulting in permanent symptoms
- Major organ / Bone marrow transplant
- Permanent paralysis of limbs
- Motor neuron disease with permanent symptoms
- Multiple sclerosis with persisting symptoms
- Accident*

*Accident means any bodily injury resulting solely and directly from accident, caused by external, violent and visible means that necessitates medical or surgical intervention or that results in disability, or disrupts in engaging in any employment or occupation of any description for more than three weeks certified by a medical practitioner.

Note: Accidents under the purview of workplace or notional extension of workplace will only be excluded for copay, rest all accidents will be subjected to copay as per the policy terms and conditions.

Critical Illness benefit for Associate only

For post recovery laboratory charges towards critical illness for Associates (first time occurrence), INR 25,000 will be paid as a onetime benefit for the period beyond 60 days of post hospitalization. This will be paid directly to the Associate upon discharge and once the first critical ailment claim is paid under the policy and there is an ongoing treatment. No co-pay for Associates if hospitalization is due to critical illness.

Loss of Pay (LOP) benefit
If during the period of insurance an Associate is diagnosed to be suffering from any critical illness on or after the commencement of the policy; has undergone hospitalization thereafter during the Policy Period and has exhausted all their leave on account of the illness resulting in LOP, the insurer will pay a weekly compensation of INR 10,000 as long as the Associate is on LOP (but not exceeding INR 500,000) till the end of the Policy Period. The benefit shall be extended only if the claim is covered under the policy. Coverage of the claim / treatment under this policy is based on the date of admission of claims and the entitlement of claims will fall within the respective Policy Period.

- If there is an active registration of claim during enrollment / renewal window, the Associate will not be able to modify the top-up benefit.
- If there is an active registration of claim during enrollment process for new joiners, Associate will not be able to modify the top-up benefit.

Following are the nature of injury resulting from an accident that are admissible for LOP benefit:

Nature of injury	Admissibility for LOP claim
Burns	Only if person becomes unconscious and is admitted in hospital or requires
Fracture	Fracture of spine, head and bone excluding hairline, fracture to fingers, toes or broken nose.
Dislocation	Dislocation of hip, knee, shoulder, and elbow
Amputation	Amputation excluding loss of fleshy tip, nail, tooth or finger
Other Injury	Crush injury, eye injury resulting in either permanent or temporary loss of sight.

Cancer Benefit
Any Associate who is diagnosed to have been suffering from Cancer on or after the commencement of the Insurance policy and who has undergone hospitalization thereafter during the Policy Period will be paid a sum of INR 100,000 as cancer benefit once during their lifetime if there is an ongoing treatment. This benefit would be in addition to the hospitalization expenses payable under the insurance policy and eligible sum insured. This benefit is applicable for an Associate only and not to any other insured person.
Following oral chemotherapy drugs are covered for associates:

- Altretamine
- All trans retinoic acid (atra)
- Busulfan
- Bexarotene
- Capacitabine
- Cyclophosphamide
- Chlorambucil
- Etoposide
- Hydroxyurea
- Leucovorin
- Lomustine
- Melphalan
- Mercaptopurine (6-mp)
- Mesna
- Methotrexate
- Mitotane
- Procarbazine
- Temozolamide
- Topotecan
- Thioguanine (6-tg)

Exclusions for cancer benefits

- Skin cancer other than invasive malignant melanoma.
- Papillary micro-carcinoma of the thyroid less than 1 cm in diameter
- Chronic lymphocytic leukemia less than RAI stage 3
- Micro carcinoma of the bladder
- Cervical dysplasia
- All tumors in the presence of HIV infection.

Gender Transition

- Associate can declare their gender transitioning and will be eligible for medical benefits under GMC policy (as per policy terms).
- GMC policy covers gender transition surgeries for the Associates (eligibility below):
    - Surgery for Hysterectomy (removal of uterus) covered up to INR 75,000
    - Surgery for Mastectomy (removal of breast) covered up to INR 75,000
    - Genital Surgery (Male to Female) covered up to INR 75,000
    - Hormonal Treatment forming part of the Pre and Post Hospitalization associated with any of the above surgeries will be covered and shall be capped at a maximum of INR 25,000.
- All the above coverages are restricted to availability of sum insured under GMC Policy. Top up cover availed, if any, will not be applicable for this benefit.
- Associates can avail their existing leave balance for the above-mentioned surgeries, post approval from HCM supervisor.
- Associates must furnish Self-Declaration and Notarized Affidavit for gender transition.
- Associate can declare and cover same sex partner (domestic partner), with respect to coverage guidelines. Associates can write to HRBenefitsIndia@cognizant.com.
    - Medical coverage for same sex partner (domestic partner) will be based on their current gender orientation.
    - Associates should furnish the following documents:
        - Self-Declaration Form
        - ID proof of the domestic partner declared.
        - Proof of living at the same residential address (any of the below).
            - Governmental proofs like Voters ID, Driving License, Passport.
            - Proofs like rental / lease agreement/ utility bill.
            - Notarized Affidavit.
- Any change to the domestic partner declaration during active Policy Period is restricted.
- Medical coverage is limited to treatment taken in India where medical units are registered under Medical Association/National Accreditation Board for health & Health Care providers (NABH).

Other Benefits

- Outpatient coverage for a maximum limit of up to INR 5,000 per child will be covered during the Policy Period, for children with disability.
- Outpatient coverage for Associates, for a maximum limit of up to INR 5,000 will be paid for expenses like CT scan, MRI or any test for head / skull injury due to an accident.
- For Associates suffering from Tuberculosis, INR 7,000 towards cost of drugs will be reimbursed.
- Bariatric surgery for Associates with BMI exceeding 35.
- Lasik power correction surgery is applicable for eye power +/- 5 and above for insured members in Base Policy (GMC) and + / -7.5 and above for insured members in AMC.
- Non-admissible components like room rent restriction, proportionate deductions, Co-pay and non-medical items (refer Annexure I) are not applicable for hospitalization resulting in the death of the Associate.
- Cochlear implant is covered up to 50% of the balance sum insured.
- 50% Co-pay will be applicable on the initial surgical proceedings in case of Cyber knife / Stem cell treatment, inclusive of the hospitalization expenses of the donor.

- Hospitalization expenses incurred on the donor during an organ transplant will be a part of the main claim.
- Coverage for treatment of genetic disorders and ailments for Associates and dependents.
- Air Ambulance in case of emergency not exceeding INR 100,000 per incident and INR 1,000,000 per year (for the entire organization). Air Ambulance can be utilized only in case of emergency for critical ailments listed in the policy and where there are no hospitals in the vicinity of 75 kilometers. For e.g., in case of immediate hospitalization required for cardiac arrest / cancer and if there are no hospitals in the vicinity of 75 kilometers, the member can utilize air ambulance service to reach the hospital as early as possible.
- Coverage for psychiatric treatment limited to inpatient, is applicable only for Associates.
- Coverage for modern treatments or procedures: The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to the limit specified against each procedure during the Policy Period.

Modern treatment or Procedure	Limit (Per Policy Period)
Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Up to 20% of Sum Insured subject to Maximum Rs. 2 Lakh
Balloon Sinuplasty	Up to 20% of Sum Insured subject to Maximum Rs. 2 Lakh
Deep Brain stimulation	Up to 50% of Sum Insured subject to Maximum Rs. 5 Lakh
Oral chemotherapy	Up to 10% of Sum Insured subject to Maximum Rs. 1 Lakh
Immunotherapy- Monoclonal Antibody to be given as injection	Up to 25% of Sum Insured subject to Maximum Rs 2 Lakh
Intravitreal injections	Up to 10% of Sum Insured subject to Maximum Rs.75,000
Robotic surgeries	Up to 50% of Sum Insured subject to Maximum Rs. 5 Lakh
Stereotactic radio surgeries	Up to 50% of Sum Insured subject to Maximum Rs. 3 Lakh
Bronchial Thermoplasty	Up to 50% of Sum Insured subject to Maximum Rs. 2.5 Lakh
Vaporization of the prostrate (Green laser treatment or holmium laser treatment)	Up to 50% of Sum Insured subject to Maximum Rs. 2.5 Lakh
IONM - (Intra Operative Neuro Monitoring)	Up to 10% of Sum Insured subject to Maximum Rs. 50,000
Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered	Up to 50% of Sum Insured subject to Maximum Rs. 2.5 Lakh

Coverage for Hospitalization/Day Care Procedure

Where admission is for a period less than 24 consecutive hours.

Anti-Rabies Vaccination	Hysterectomy
Appendectomy	Inguinal/Ventral/Umbilical/Femoral Hernia

Coronary Angiography	Lithotripsy (Kidney Stone Removal)
Coronary Angioplasty	Parenteral Chemotherapy
Dental surgery following an accident	Piles / Fistula
Dilatation & Curettage (D & C) of Cervix	Prostate
Eye surgery	Radiotherapy
Fracture / dislocation excluding hairline Fracture	Sinusitis
Gastrointestinal Tract system	Stone in Gall Bladder, Pancreas, and Bile Duct
Hemodialysis	Tonsillectomy
Hydrocele	Urinary Tract System

Aside from those on the afore mentioned list, any further surgeries or procedures that are agreed upon by the TPA or insurer and necessitate less than a 24-hour hospital stay are also covered.

Terms and Conditions

Medical Expenses Falling Under Two Policy Periods

If the claim event falls within two Policy Periods, the claims shall be paid taking into consideration the available sum insured of the expiring policy only. Sum Insured of the renewed policy will not be available for the hospitalization (including Pre & Post Hospitalization expenses), which has commenced in the expiring policy. Claim shall be settled on per event basis.

Fraud, Misinterpretation, Concealment

The policy shall be null, and void and no benefits shall be payable in the event of misinterpretation, misrepresentation, or nondisclosure of any material fact/particulars if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the insured person or by any other person acting on their behalf.

Notice of claim

Preliminary notice of claim with particulars relating to policy number, name of insured person in respect of whom claim is to be made, nature of illness / injury and name and address of the attending medical practitioner / hospital / nursing home should be given to the company / TPA within seven (7) days from the date of hospitalization in respect of reimbursement claims.

Final claim along with hospital receipted original bills / cash memos, claim form and documents as listed in the claim form below should be submitted to the policy issuing office / TPA not later than 30 days of discharge from the hospital. The insured may also be required to give the Company / TPA such additional information and assistance as the company / TPA may require in dealing with the claim.

- Bill, receipt and discharge certificate / card from the hospital.
- Cash memos from the hospitals(s) / chemists(s), supported by proper prescriptions.
- Receipt and pathological test reports from pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such pathological tests / pathological.
- Surgeon's certificate stating nature of operation performed and surgeons' bill and receipt.
- Attending doctor's/ consultant's/ specialist's / anesthetist's bill and receipt, and certificate regarding diagnosis.
- Certificate from attending medical practitioner / surgeon that the patient is fully cured.

Waiver

Waiver of period of intimation may be considered in extreme cases of hardships where it is proved to the satisfaction of the company/TPA that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit. This waiver cannot be claimed as a matter of right.

Physical Examination
Any medical practitioner authorized by the insurer shall be allowed to examine the insured person in case of any alleged injury or illness requiring hospitalization when and so often as the same may reasonably be required on behalf of the insurer.
The insurer shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the insured person or by any other person acting on his behalf.

Multiple Policies

- In case of multiple policies taken by insured person during a period from insurer or one or more insurers to indemnify treatment costs, insured person shall have the right to require a settlement of insured person's claim in terms of any of one of the policies. In all such cases the insurer, if chosen by insured person, shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of this policy.
- Insured having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the Sum Insured is not exhausted. Then insurer shall independently settle the claim subject to the terms and conditions of this policy.
- Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.
- The insured person must disclose such other insurance at the time of making a claim under this policy.

The scope of ailments covered under this policy is as per the Group Mediclaim Policy issued by the primary insurer. The same shall be applicable to all Associates and enrolled dependents under the Base Cover / Additional Member Cover (AMC) /Top-up Cover, which will be a floater policy.

Refer Annexure I, for details on non-medical expenses not covered by this policy, items that are to be subsumed into costs of treatment, items that are to be subsumed into procedure charges and items that are to be subsumed into room charges. For general exclusions, refer Annexure II.

In the event, an insured person has any grievance relating to the hospitalization claim, they may contact HR talent partner/HR business partner/TPA/location HR leads. The case would be further referred to Cognizant ombudsman team.

Process

Claim Submission Process

- Medical Insurance may be availed through cashless transaction (via Network Hospital) or reimbursement process, by submitting claim documents to Medi Assist team at Cognizant MEPZ office in Chennai at the below mentioned address:

  Cognizant Technology Solutions India Pvt Limited
  Payroll & Benefits shared services (PF & EPS Team)
  MEPZ-Special Economic Zone,
  Plot No A-17, D-2, C-10 & C-1, A-15 to 17, B-20 & A-33
  National Highway 45, Tambaram, GST road, Chennai 600045.

  Alternately, hard copies can also be couriered to Medi Assist Chennai address as mentioned below:

  Medi Assist (TPA)
  RWD Atlantis Building, 2nd Floor,
  Door No: 24, Nelson Manickam Road,
  Aminjikkarai, Chennai 600029

- All reimbursement claims will be settled by the insurer and NEFT will be initiated directly by the insurer to the bank account of the associate as updated in Medi Assist app.
- For any assistance during hospitalization, Associates may contact the 24/7 dedicated India toll free number 1800-258-5895, Toll number +91 7337700014 which is exclusive for Cognizant Associates in India.
- Associates from outside of India, can get in touch with Medi Assist on their International landline number - (International call prefix) 91 80 67617555 (chargeable as per Telecom tariff).

Claim Submission Process for Network Hospitals

- The period of hospitalization should be greater than 24 hours with an active line of treatment.
- Claim for hospitalization in a network hospital will be taken care through the cashless mode.
- Associates will have to submit the pre-authorization form by clicking “Intimate e-Cashless Hospitalization” in the Medi Assist app, seven (7) days prior to the date of admission for a planned hospitalization, to avail the cashless benefit.
- Medi Assist shall validate and provide necessary approvals for the pre-authorization submitted.
- The Associate will receive a pay confirmation receipt, once Medi Assist approves the pre-authorization via e-mail. The Associate can also access the information by logging into the Medi Assist app under “Your Claims”.
- The cost of non-medical expenses, (refer Annexure I) Co-pay, proportionate charges or any other deductions as per the policy will have to be borne by the Associate.
- In case of any denial of cashless claims, Associates can claim through the reimbursement mode (subject to terms and conditions of the policy).
- Associates will have to claim pre and post hospitalization only through the reimbursement mode.

Claim submission process for Non-Network Hospitals

- The treatment can be taken from any of the Registered Hospitals / Nursing Home / Clinics in India.
- The period of hospitalization should be greater than 24 hours with an active line of treatment.
- Associates will have to send intimation about their reimbursement claim before the discharge from the hospital by clicking “Intimate Reimbursement” in the Medi Assist app..
- Associates will have to declare and submit their reimbursement claims within 30 days from the date of discharge by clicking “Submit claim” in the Medi Assist app.
- Associates should fill in the claim form completely, take a printout and attach it along with the original documents required.
- Mandatory documents required to claim reimbursement include original hard copies of bills, breakup of bills, prescriptions, discharge summary, receipts and investigation reports.
- Associates will have to ensure that the claim documents reach Medi Assist Chennai office address mentioned above within 30 days from the date of discharge.

  Note:
  - Original reports must be furnished with original bills and receipts. In case of X-rays, an X-ray original report from the hospital needs to be submitted.
  - If Associates are attaching medicine bills, it must be accompanied by corresponding original prescriptions.
  - All bills for medical investigation and diagnostic tests must be accompanied by original reports.
  - Associates should retain photocopies of all documents/reports/bills submitted for further reference as documents once submitted will not be returned by the insurance company.

Claim	Timelines for submission
Main Hospitalization Claim	Within 30 days from the date of discharge
Pre-Hospitalization expenses	Within 30 days from the date of discharge
Post-hospitalization expenses	Within 30 days from the completion of post hospitalization period Post hospitalization period: 60 days from the date of discharge

Claim submission process in case of additional documents

- In case of any additional documents required, three reminders will be sent to Associates over a period of 21 days mentioning the documents required.
- Reminders will be sent to Associate's Cognizant e-mail ID.
- In case the Associate does not respond to the e-mails, the claim will be repudiated as "document recovery failure". Claims shall not get processed until the Associate submits the pending documents.
- Associates will have to collect the required pending documents and send it to Medi Assist within 10 days from the date of third reminder, along with a delayed submission clarification letter.
- The discharge summary issued by the hospital should include the details in the hospital's letter head, duly signed by the concerned doctor and affixed with the hospital's seal.
- Medi Assist will process the Associate's claim as per the norms of the insurance policy. If all the documents have been submitted, the claim will be validated, post which, the same will be sent to the insurance company for reimbursement.
- Typical processing time is 30 days from the date of submission of hard copies of documents to Medi Assist Chennai office.
- Claim can be tracked through the Medi Assist app.

Midterm enrolment process

- Associates can make changes to their dependent details, only at the time of joining or during the renewal of the policy (Enrollment Window period). However, Midterm inclusion of newly wedded Spouse and newborn child can be done in the Medi Assist app.
- Associate will be able to add their newly wedded Spouse as their dependent within 45 days from the date of marriage by raising a GSD or by writing to Medi Assist at ctsenrollment@mediassist.in
- Associate will be able to add their newborn child as their dependent within 45 days from the date of birth. Addition is subject to availability of vacant slots in the base / AMC policy. If there are no vacant slot available in the Base and AMC Policy, Associate may replace any one of the existing dependents in the Base Policy who has not made any claim during the current Policy Period. Under the AMC policy, no change to existing dependents will be allowed during the middle of the Policy Period.

Medi Assist mobile app

- Associates can alternatively use the Medi Assist mobile app for medical insurance services.
- Medi Assist mobile app can be downloaded from the play store or Appstore.
- Associates will have to use their Cognizant mail id and windows password to login to the Medi Assist app.
- The app facilitates the following services:
    - Check claim status.
    - View / Download Medi Assist e-cards.
    - Finding the nearest Network Hospitals
    - Book appointments for Master Health Checkup
    - Review e-cashless transactions & processes
    - Receive alerts on reimbursement, etc.

Responsibility Matrix

Associate
Submit claim documents to the Medi Assist helpdesk at MEPZ Chennai Cognizant office.

Alternately, hard copies can also be couriered to Medi Assist Chennai address as mentioned below:

Medi Assist (TPA)
RWD Atlantis Building, 2nd Floor,
Door No: 24, Nelson Manickam Road,
Aminjikkarai, Chennai 600029

Medi Assist
Third party claim administrator.

Exception management

The benefits of this policy are governed by the terms and conditions of employment in practice at Cognizant. This is subject to change from time to time. Cognizant reserves the right to amend its policies as necessitated. All statutory requirements are applicable as mandated by law. All exceptions to policies will be directed to the HR India Benefits.

Policy modifications

Cognizant reserves the right to amend its policies as necessary. Any changes to the Group Medical Insurance Policy will be approved the Head of Human Resources – India. Associates are required to raise GSD through service now for any queries.

Version history

Revision date	Description of change
Nov-01-2012	Initial Release, based on practice and precedence in Cognizant India. Introduction of new levels, titles, template and version control
Nov-01-2013	Annual review and process changes, if any, incorporated
Nov-01-2013	Addition in AMC room rent charges and expenses covered
Nov-01-2014	Annual review and process changes, if any, incorporated
Nov-01-2015	Annual review and process changes, incorporated clarification on Coverage of medical insurance for Associates hired in India and taking onsite assignments
Apr-01-2015	Change in Address incorporated for medical insurance document delivery during BCP
Apr-01-2015	Change in Address incorporated for medical insurance document delivery
Nov-01-2015	Change in service tax. AMC and Top-up table updated with revised values
Nov-01-2016	Annual review and process changes, if any, incorporated
Nov-01-2017	Change in third party administrator. Annual review and process changes, if any
Nov-01-2017	Clarity on AMC Coverage
Nov-01-2018	Annual review and process changes incorporated
Nov-01-2018	Inclusion of medical insurance benefit for LGBTQ
Nov-01-2019	Annual review and process changes
May-01-2020	Top-Up Coverage for COVID 19 for India Hires and Dependents

Nov-01-2020	Annual review and process changes, Introduction of Covid19 rider for Covid 19 treatment, Increase in Top-up Limits, enhanced Maternity Limits
Nov-01-2021	Coverage for Covid 19 for India Hires and deputed assignees dependents based out of India
Nov-01-2021	Annual review and process changes
Nov-01-2022	Standardization of the Template Annual review and process changes, Changes in Covid 19 rider plan benefit
Nov-01-2023	Annual review and process changes
Nov-01-2024	Annual review change in copay for employee spouse and children. No ICU room rent capping; Change of address

Policy control information

Policy Name: Group Medical Insurance Policy - India

Department: Human Resources

Revision Date: NOV-01-2024

Effective Date: NOV-01-2024

Policy Owner: Head of HR - India

Annexure I

List I – Items for which coverage is not available in the policy

S No	Item
1	Baby food
2	Baby utilities charges
3	Beauty services
4	Belts / braces
5	Buds
6	Cold pack / hot pack
7	Carry bags
8	Email / Internet Charges
9	Food Charges (other than patient's diet provided by hospital)
10	Leggings
11	Laundry Charges
12	Mineral Water
13	Sanitary Pad
14	Telephone Charges
15	Guest Services
16	Crepe Bandage
17	Diaper of any type
18	Eyelet Collar
19	Slings
20	Blood Grouping and Cross Matching of Donors Samples
21	Service Charges Where Nursing Charge Also Charged
22	Television Charges
23	Surcharges
24	attendant charges
25	Extra Diet of Patient (other than that which forms part of bed charge)
26	Birth Certificate
27	Certificate Charges
28	Courier Charges
29	Conveyance Charges
30	Medical Certificate
31	Medical Records
32	Photocopies Charges
33	Mortuary Charges
34	Walking Aids Charges
35	Oxygen Cylinder (for Usage Outside the Hospital)
36	Spacer
37	Spirometer

38	Nebulizer Kit
39	Steam Inhaler
40	Arm sling
41	Thermometer
42	Cervical Collar
43	Splint
44	Diabetic Footwear
45	Knee Braces (Long / Short / Hinged)
46	Knee Immobilizer / Shoulder Immobilizer
47	Lumbo Sacral Belt
48	Nimbus Bed or Water or Air Bed Charges
49	Ambulance Collar
50	Ambulance Equipment
51	Abdominal Binder
52	Private Nurses Charges - Special Nursing Charges
53	Sugar Free Tablets
54	Creams Powders Lotions (Toiletries Are Not Payable, Only Prescribed Medical Pharmaceuticals Payable)
55	Ecg Electrodes
56	Gloves
57	Nebulization Kit
58	Any Kit with No Details Mentioned (Delivery Kit, Ortho kit, Recovery Kit, Etc.)
59	Kidney Tray
60	Mask
61	Ounce Glass
62	Oxygen Mask
63	Pelvic Traction Belt
64	Pan Can
65	Trolly Cover
66	Uro-meter, Urine Jug
67	Ambulance
68	Vasofix Safety

List II - Items that are to be subsumed into room charges

S No	Item
1	Baby Charges (Unless Specified/Indicated)
2	Hand Wash
3	Shoe Cover
4	Caps
5	Cradle Charges
6	Comb
7	Eau-De-Cologne/Room Fresheners
8	Foot Cover
9	Gown
10	Slippers
11	Tissue Paper
12	Toothpaste
13	Toothbrush
14	Bed Pan
15	Face Mask
16	Flexi Mask
17	Hand Holder
18	Sputum Cup
19	Disinfectant Lotions
20	Luxury Tax
21	Hvac
22	House Keeping Charges
23	Air Conditioner Charges
24	Im Iv Injection Charges
25	Clean Sheet
26	Blanket/Warmer Blanket
27	Admission Kit
28	Diabetic Chart Charges
29	Documentation Charges/Administrative Expenses
30	Discharge Procedure Charges
31	Daily Chart Charges
32	Entrance Pass/Visitors Pass Charges
33	Expense Related To Prescription On Discharge
34	File Opening Charges
35	Incidental Expenses/Misc. Charges (Not Explained)
36	Patient Identification Band/Name Tag
37	Pulse oximeter Charges

List III - Items that are to be subsumed into procedure charges

S No	Item
1	Hair Removal Cream
2	Disposables Razors Charges (For Site Preparations)
3	Eye Pad
4	Eye Shield
5	Camera Cover
6	DVD, Cd Charges
7	Gause Soft
8	Gauze
9	Ward And Theatre Booking Charges
10	Arthroscopy And Endoscopy Instruments
11	Microscope Cover
12	Surgical Blades, Harmonic scalpel, Shaver
13	Surgical Drill
14	Eye Kit
15	Eye Drape
16	X-Ray Film
17	Boyles Apparatus Charges
18	Cotton
19	Cotton Bandage
20	Surgical Tape
21	Apron
22	Torniquet
23	Ortho bundle, Gynaec Bundle

List IV - Items that are to be subsumed into costs of treatment

S No	Item
1	Admission/Registration Charges
2	Hospitalization For Evaluation/Diagnostic Purpose
3	Urine Container
4	Blood Reservation Charges and Ante Natal Booking Charges
5	Bipap Machine
6	Cpap/ Capd Equipment
7	Infusion Pump – Cost
8	Hydrogen Peroxide/Spirit/Disinfectants Etc.
9	Nutrition Planning Charges - Dietician Charges - Diet Charges
10	HIV Kit
11	Antiseptic Mouthwash
12	Lozenges
13	Mouth Paint
14	Vaccination Charges
15	Alcohol Swabs
16	Scrub Solution/ Sterillium
17	Glucometer & Strips
18	Urine Bag

Annexure II

General Exclusions

- Injury or disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, War like operations (whether war be declared or not) or by nuclear weapons / materials.
- Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident).
- Vaccination, inoculation or change of life or cosmetic or of aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.
- Surgery for correction of eyesight, cost of spectacles, contact lenses, hearing aids.
- Any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear unless arising from disease. Except for injury due to accident and which requires hospitalization for treatment.
- Convalescence, general debility, “run down” condition or rest cure or defects or anomalies, sterility, or assisted conception procedure, venereal diseases, intentional self-injury/suicide, all psychiatric and psychosomatic disorders and diseases / accident due to and or use, misuse or abuse of drugs / alcohol or use of intoxicating substances or such abuse or addiction etc.
- Any cosmetic or plastic surgery except for correction of injury.
- Expenses incurred at hospital or nursing home primarily for evaluation / diagnostic purposes which is not followed by active treatment for the ailment during the hospitalized period.
- Expenses on vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending physician.
- Any treatment arising from or traceable to pregnancy, miscarriage, abortion, or complications of any of these including changes in chronic condition as a result of pregnancy except were covered under the maternity section of benefits.
- Doctor's home visit charges, attendant / nursing charges during pre and post hospitalization period.
- Treatment which is continued before hospitalization and continued even after discharge for an ailment/ disease/ injury different from the one for which hospitalization was necessary.
- Naturopathy treatment, unproven procedure, or treatment, experimental or alternative medicine and related treatment including acupressure, acupuncture, magnetic and such other therapies.
- External and or durable medical / non-medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Infusion pump etc., Ambulatory devices i.e., walker, crutches, belts, collars, caps, splints, slings, braces, stockings of any kind, diabetic footwear, glucometer / thermometer, and similar related items and any medical equipment which is subsequently used at home etc.
  Note: Cost of braces will not be covered if cosmetic in nature.
- All non-medical expenses including personal comfort and convenience items or services such as telephone, television, aaya / barber or beauty services, diet charges, baby food, cosmetics, napkins, toiletry items etc., guest services and similar incidental expenses or services etc. Change of treatment from one pathy to other pathy unless being agreed / allowed and recommended by the consultant under whom the treatment is taken.
- Treatment of obesity or condition arising therefrom (including morbid obesity) and any other weight control program, services or supplies etc.
- Any treatment required arising from Insured's participation in any hazardous activity including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing etc. unless specifically agreed by the Insurance Company.

- Any treatment received in convalescent home, convalescent hospital, health hydro, nature care clinic or similar establishments.
- Any stay in the hospital for any domestic reason or where no active regular treatment is given by the specialist.
- Massages, steam bathing, shirodhara and alike treatment under ayurvedic treatment.
- Any kind of service charges, surcharges, admission fees / registration charges levied by the hospital.
- Outpatient diagnostic, medical or surgical procedures or treatments, non-prescribed drugs and medical supplies, Hormone replacement therapy.
- Expenses incurred for investigation or treatment irrelevant to the diseases diagnosed during hospitalization or primary reasons for admission. Private nursing charges, Referral fee to family doctors, out station consultant's / Surgeons' fees.
- Intentional self-Injury, outpatient treatment.
- Family planning surgeries (Vasectomy or tubectomy).
- All expenses arising out of any condition directly or indirectly caused by or associated with Human T-cell Lymphotropic Virus Type III (HTLD - III) or Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of similar kind commonly referred to as AIDS, HIV and its complications including sexually transmitted diseases.
- External and or durable Medical / Non-medical equipment of any kind used for diagnosis and or treatment like prosthetics etc.
- Lasik treatment or any other procedure for correction/enhancement of vision is < +/- 5.
- Any device/instrument/machine that does not become part of the human anatomy/body but would contribute/replace the function of an organ is not covered.
- Warranted those treatments on trial/experimental basis are not covered under scope of the policy.
- Coverage for palliative care and palliative chemotherapy is limited to 50% of the current base sum insured for dependents.
- This policy does not cover expenses incurred on account of domiciliary hospitalization (a situation where medical treatment is administered within the precincts of the patient's residence).
- This policy does not cover any other Outpatient treatment except OPD treatment for children with disability and for Associates with suspected head/skull injury due to accidents.
- This policy also doesn't cover hospitalization for observation/ evaluation/ diagnostic/ investigation procedure and oral medications (except those covered under pre and post hospitalization expenses).
- Medical treatment such as ongoing hormone therapy, voice correction, vocal cord alignment and cosmetic surgery will not be eligible for Coverage.
- Outpatient treatment for gender realignment will not be eligible for Coverage.
- Dependents are not eligible for coverage of gender realignment benefit.
- Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
- Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.
- Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
- Expenses related to sterility and secondary infertility. This includes.
    - Any type of contraception, sterilization
    - Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

    - Gestational Surrogacy
    - Reversal of sterilization
- Treatment taken outside India.
- Change of treatment from one system to another unless recommended by the consultant / hospital under whom the treatment is taken.
- Service charges or any other charges levied by hospital, except registration/admission charges.
- Treatment such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.
- If cap limits are met there is no coverage for pre and post hospitalization expenses

Annexure III

Gender Transition – Affidavit Template

Date:

To,

The New India Assurance Co. Ltd

Tarapore towers,

3rd floor, 826, Anna Salai

Chennai,

Tamil Nadu – 600002

AFFIDAVIT

I,<name>, aged about <age> years, and employed as <designation> with Cognizant Technology Solutions India Private Limited ('Cognizant') having its office at No. 5/535, Old Mahabalipuram Road, Okkiam, Thoraipakkam, Chennai – 600097, do hereby solemnly affirm and declare as under:

1. That I am employed as <designation> and I am part of the Cognizant since <DOJ>.

2. I hereby declare and affirm that I am undergoing Gender Transition treatment under the supervision of registered medical practitioner at <name and place of hospital>. It is certified that I have complied with other legal requirements in the connection.

3. That the above-mentioned contents of this affidavit are true and correct to the best of my knowledge, belief, and information.

Deponent

VERIFICATION

Verified at <place> on this <date> day of <month> 2022 that the contents of the above affidavit are true and correct.

Deponent

Annexure IV

Gender Transition – Self Declaration Template

Date:

To

Cognizant Technology Solutions India Pvt. Ltd.

5/535, Old Mahabalipuram Road,

Okkiyam, Thoraipakkam

Chennai - 600097

I, <name>, aged about <age> years, and employed as <designation> with Cognizant Technology Solutions India Private Limited ('Cognizant') having its office at No. 5/535, Old Mahabalipuram Road, Okkiam, Thoraipakkam, Chennai – 600097, do hereby solemnly affirm and declare as under:

1. That I am employed as <designation> and I am part of the Cognizant since <DOJ>.
2. I hereby declare and affirm that I am undergoing Gender Transition treatment under the supervision of registered medical practitioner <name of medical practitioner> at <name and place of hospital>. Medical practitioner certificate certifying the Gender Transition treatment is being shared along with this declaration form.
3. My transition is from <current gender> to <transitioned gender>. Henceforth I would like to be referred as <New Name>.
4. I authorize Cognizant to verify relevant records pertaining to my gender transition and make necessary amendments in the respective systems.
5. It is certified that I have complied with other legal requirements in the connection.
6. That the above-mentioned contents of this declaration are true and correct to the best of my knowledge, belief, and information.

Yours Sincerely,
<<Signature>>
<<Name>>
<<Associate id>>
<<Current work location>>

Annexure V

Same Sex Partner – Affidavit Template

Date:

To,

The New India Assurance Co. Ltd

Tarapore towers,

3rd floor, 826, Anna Salai

Chennai,

Tamilnadu – 600002

AFFIDAVIT

I,<name>, aged about <age> years, and employed as <designation> with Cognizant Technology Solutions India Private Limited ('Cognizant') having its office at No. 5/535, Old Mahabalipuram Road, Okkiam, Thoraipakkam, Chennai – 600097, do hereby solemnly affirm and declare as under:

1. That I am employed as <designation> and I am part of the Cognizant since <DOJ>.

2. I hereby declare and affirm that the Mr. /Ms. /Mx. <name>, is my same sex domestic partner with whom I share residence having address at <detailed address>.

3. That the above-mentioned contents of this affidavit are true and correct.

Deponent

VERIFICATION

Verified at <place> on this <date> day of <month> 2022 that the contents of the above affidavit are true and correct.

Deponent

Annexure VI

Same Sex Partner – Self-Declaration Template

Date:

To

Cognizant Technology Solutions India Pvt. Ltd.

5/535, Old Mahabalipuram Road,

Okkiyam, Thoraipakkam

Chennai - 600097

I,<name>, aged about <age> years, and employed as <designation> with Cognizant Technology Solutions India Private Limited ('Cognizant') having its office at No. 5/535, Old Mahabalipuram Road, Okkiam, Thoraipakkam, Chennai – 600097, do hereby solemnly affirm and declare as under:

1. That I am employed as <designation> and I am part of the Cognizant since <DOJ>.
2. I hereby declare and affirm that the Mr. /Ms. /Mx. <name>, is my same sex domestic partner with whom I share residence having address at <detailed address>.
3. That the above-mentioned contents of this declaration are true and correct.

Yours Sincerely
<<Signature>>
<<Name>>
<<Associate id>>

<<Current work location>>